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# ERRATA

In: Vemer P, Krabbe PFM, Feenstra TL, van Voorn GAK, et al. Improving model validation in HTA: comments on the guidelines of the ISPOR-SMDM Modeling Good Research Practices Task Force. Value Health. 2013;16:1106-7.

The correct authors listing should be as follows: Pepijn Vemer, MSc, George A.K. van Voorn, PhD, Isaac Corro Ramos, PhD, Paul F.M. Krabbe, PhD, Maiwenn J. Al, PhD, Talitha L. Feenstra, PhD

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[4] Peters B, Smith J, Medeiros D, Rohrer M, eds. How to build valid and credible simulation models. In: 2001 Winter Simulation Conference, Arlington, VA, December 9-12, 2001.

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In: Abstract PMH19, "Association between cognitive function and 3 month healthcare costs among patients initiating an antidepressant for depressive disorder in an ambulatory care setting" by Kurlander JL, MS[1]; Walker V, Essoi B, Samp JC, Yang, J, Akhras KS (Value Health 2013;16:A544). This poster was presented at the ISPOR 16th Annual European Congress in Dublin, Ireland on November 5th, 2013.

The correct full text of the abstract appears below.

**PMH19**

**ASSOCIATION BETWEEN COGNITIVE FUNCTION AND 3 MONTH HEALTHCARE COSTS AMONG PATIENTS INITIATING AN ANTIDEPRESSANT FOR DEPRESSIVE DISORDER IN AN AMBULATORY CARE SETTING**

Kurlander JL, MS[1]; Walker V McS[1]; Essoi B, MPH[1]; Samp JC, PharmD, MS[2]; Yang, J, PhD[2]; Akhras KS, PharmD[2]

[1]*OptumInsight, MN002-0258, 12125 Technology Drive, Eden Prairie, MN 55344,* [2]*Takeda Pharmaceuticals Inc., One Takeda Parkway, Deerfield, IL 60015*

**Objectives**: Depression is associated with reduced cognitive function and significant healthcare costs; however, the extent to which these two are related remains unclear. This study compared follow-up healthcare costs for major depressive disorder patients with and without cognitive dysfunction after antidepressant (AD) initiation. **Methods**: A large US health plan affiliated with OptumInsight was used to identify depressed patients with a newly prescribed AD who could be surveyed to assess cognitive function. Patients with neurological diseases associated with cognitive dysfunction were excluded. Patients were mailed a survey invitation and consent form. Patients maintained eligibility by confirming a depressive diagnosis and no excluding diagnoses. Consenting, eligible patients were interviewed by telephone and completed 4 cognitive function tests. Patients were classified as "cognitive normal (CN)" or "cognitive dysfunction (CD)" based on test scores relative to normative data. All-cause healthcare costs in the 3 months post-AD initiation were calculated from pharmacy and medical claims. T-tests compared 3-month costs of CN versus CD. Gamma models with log link compared healthcare costs between CD and CN patients, adjusting for race, sex, age, education, employment, depression severity, and comorbidities. **Results**: 13,537 patients were invited to participate in the study and 564 patients maintained eligibility and completed the study. Patients were mostly female (80%), mean age was 41 years, 98% had a high school degree or higher, and 84% were employed. A total of 45% (n=255) met criteria for CD. Mean healthcare costs were $3,053 for all patients. Costs were $3,948 for the CD group compared to $2,312 for the CN ($p = 0.113$). In the gamma models with costs as the outcome, CD patients had costs 1.46 times higher than CN patients (95% CI: 1.12, 1.92)($p=0.0059$). **Conclusions**: In this study population, healthcare costs were significantly higher in patients with cognitive dysfunction compared to those without cognitive dysfunction.

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